

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |  |                            |  |
|---|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                               |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155368</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>11/12/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TODD-DICKEY NURSING AND REHABILITATION</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>712 W 2ND ST</b><br><b>LEAVENWORTH, IN 47137</b>                             |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| {K 000}   | <p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Short form Life Safety Code Recertification and State Licensure Survey conducted on 09/22/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/12/15</p> <p>Facility Number: 000490<br/>Provider Number: 155368<br/>AIM Number: 100291320</p> <p>At this PSR survey, Todd Dickey Nursing and Rehabilitation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 62 and had a census of 45 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. There was a twenty four foot by twenty four foot wood framed garage approximately two hundred feet away from the building used for the storage of maintenance supplies which was not sprinklered.</p> | {K 000}  |  |                            |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| {K 000}   | Continued From page 1<br>Quality Review completed on 11/16/15 - DA   | {K 000}  |  |                            |  |